CONFIDENTIAL

EL DORADO COUNTY HEALTH & HUMAN SERVICES AGENCY, BEHAVIORAL HEALTH DIVISION

ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Please note that the AOT Program does not have the authority to mandate medication or involuntary long-term hospitalization/conservatorship.

Please fax completed form to (530) 303-1526 or mail to: EDC HHSA, Behavioral Health, ATTN: Utilization Review, 768 Pleasant Valley Road, Suite 201, Diamond Springs, CA 95619

IF THIS IS A PSYCHIATRIC EMERGENCY PLEASE CALL ACCESS CENTER 1-800-929-1955 OR DIAL 911

***INSUFFICIENT DETAILS MAY DELAY THE REFERRAL PROCESS**

Attach recent photo here

DATE COMPLETED: ______________

INDIVIDUAL COMPLETING REFERRAL

AGENCY: ______________________________ NAME: ________________________ RELATION TO CANDIDATE: __________________

PHONE: ___________________ EMAIL: ____________________________________ FAX: ________________________________

AOT CANDIDATE INFORMATION

SSN: ___________________________

Client ID: ____________________

LAST NAME: ___________________ FIRST NAME: _____________________ GENDER: MALE FEMALE OTHER: _________________

DOB: _________________ HEIGHT: ___________ WEIGHT: _______ HAIR COLOR: _____________ EYE COLOR: _____________

ADDRESS: ____ CITY: ______________________ ZIP: _____________

If homeless, specify location (e.g. corner of 6th/Vermont) (Required)

PHONE NUMBER: ___________________ PREFERRED LANGUAGE: ___________________ CANDIDATE SERVED IN THE U.S. MILITARY

RACE/ETHNICITY: WHITE/NON-HISPANIC HISPANIC NATIVE AMERICAN/ALASKAN AFRICAN AMERICAN ASIAN UNKNOWN MULTIRACE OTHER: ____

CURRENT LIVING SITUATION:

HOMELESS HOMELESS SHELTER HOSPITAL HOUSING/APT JAIL/CORRECTIONAL FACILITY SOBRIETY

PSYCHIATRIC FACILITY WITH FAMILY/ADULT UNKNOWN SPECIFY AGENCY: ____

INSURANCE: CHECK ALL THAT APPLY

MED-ICAL MEDICARE PRIVATE NONE OTHER _____________________________ UNKNOWN

BENEFITS: CHECK ALL THAT APPLY AND INDICATE AMOUNTS NONE

GR RECIPIENT $ ____ V.A. $ ____ SSI $ ____ SSDI $ _______ PENDING UNKNOWN OTHER $ __________________

CONSERVATORSHIP YES NO IF YES, PLEASE LIST DATES, PHONE NUMBERS AND NAMES:

SUBSTANCE ABUSE NEVER USED CURRENTLY USING PAST USE UNKNOWN AGE FIRST USED ________

LIST TYPE (S) OF SUBSTANCE ABUSED & FREQUENCY: ____

INDIVIDUAL RECEIVED SUBSTANCE ABUSE TREATMENT: YES NO TREATMENT PROGRAM ____________________________________

PHYSICAL HEALTH ISSUES AND MEDICATION: ____

MENTAL HEALTH DIAGNOSIS: ____

LIST MENTAL HEALTH MEDICATIONS: ____

COMPLIANCE WITH MENTAL HEALTH MEDICATION

TAKES MEDS REGULARLY SOMETIMES TAKES MEDS NEVER TAKES MEDS NO MEDICATIONS PRESCRIBED

TAKES MEDS MOST OF THE TIME RARELY TAKES MEDS REFUSES MEDS UNKNOWN OTHER: _______________

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

YES NO IF YES, AGENCY: ____ PHONE: ____________________________

TYPE OF SERVICES PROVIDED: ____

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NAME: ______________________________

Client ID: ______________________________

	LIST DATES OF ADMISSION & DISCHARGE		DESCRIBE REASON FOR ADMISSION
NO. OF ARRESTS IN THE PAST 36 MONTHS: ______			
NO. OF PSYCH HOSPITALIZATIONS IN THE PAST 36 MONTHS: _____			

	LIST DATES	NO. OF TIMES POLICE HAVE BEEN CALLED	DESCRIBE ACT OF VIOLENCE
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS SELF: ______			
NO. OF ACTS OF SERIOUS VIOLENCE TOWARDS OTHERS: ____			

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Describe candidate's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including danger to self and others

Describe how the candidate is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION** (e.g. unable to care for self or provide food, clothing, or shelter)

Describe the candidate's **HISTORY OF NON-COMPLIANCE WITH TREATMENT** (has been offered the opportunity to participate in treatment and fails to engage)

For Administrative Use Only **DATE REVIEWED:** ________________ **ATTEMPTED TO CONTACT REFERRING PARTY ON:** ____________

CANDIDATE MET AOT CRITERIA **CANDIDATE DID NOT MEET AOT CRITERIA** **REFERRING PARTY INFORMED** **DATE:** ____________ **STAFF NAME:** ______________________________

REASON: ____